ADOA-ASET
Arizona Strategic Enterprise Technology

Project Investment Justification

Version 01.01

A Statewide Standard Document for Information Technology Projects

Project Title:

Program Integrity Data Analytics Solution

Agency Name:	**AHCCCS**
Date:	**March 2, 2015**
Agency Contact Name:	**Joanne Obenour**
Agency Contact Phone:	
Agency Contact Email:	

Hover for Instructions

I. Management Summary*

AHCCCS seeks to award a contract, through the competitive Request for Proposal (RFP) process, for contractor managed data integrity and fraud detection services in order to support program integrity activities for Medicaid and Medicare in Arizona, which are required in order to maintain federal program compliance. The contracted solution will assist in identifying potential sources to pursue recovery of both State and Federal funds. The new contract will replace an existing contract which expires June 30, 2015.

The Pre-PIJ described the issuance of the RFP. This full PIJ describes the proposed contract solution. The initial term of the contract is for three years, with two optional two-year extensions, giving the maximum term of seven years. The total estimated cost is $3 million.

II. Project Investment Justification (PIJ) Type*

☐ **Yes** ☒ **No** Is this document being provided for a Pre-PIJ / Assessment phase?

If Yes,

Identify any cost to be incurred during the Assessment phase.	$0
Based on research done to date, provide a high-level estimate or range of development costs anticipated for the full PIJ.	$0

Explain:
Click here to enter text.

☒ **Yes** ☐ **No** Will a Request for Proposal (RFP) be issued as part of the Pre-PIJ or PIJ?

III. Business Case

*A. Business Problem**

AHCCCS currently provides coverage to approximately 1.5 Million members, primarily through contracts with Managed Care Organizations (MCOs), and has approximately 55,000 active providers who carry out the provisions of Medicaid program in Arizona. The contract for Program Integrity Data Analytics expires in June 2015, but the need for such services continues.

The AHCCCS Office of the Inspector General currently uses and will continue to need a cost-effective solution to administer, plan, and evaluate the performance and utilization of the State's programs, MCOs, providers, and members.

An Advance Planning Document (APD) has been submitted to the Centers of Medicare and Medicaid Services (CMS) to award the contract to the proposed vendor and expend the federal funds, and this PIJ is being submitted to ASET for State approval to award the contract and expend State funds.

The proposed contract will also be utilized by Med-QUEST, Hawaii's Medicaid Program

*B. Proposed Business Solution**

Award a new contract to the proposed vendor for the Implementation of the software/services needed to continue Medicaid fraud detection.

The recommended solution meets all of the mandatory requirements, and all but the following optional requirements:

- Geo-spatial representations – will be integrated by 12/31/2015
- Provider screening – available at additional cost
- Member eligibility determination – available at additional cost
- Appropriateness and cost effectiveness of care – unsupported

Note: All vendors offering provider screening, member eligibility determination and appropriateness and cost effectiveness of care, priced these items separately.

This solution is the same one we have been using for the past five years. As a result, there will be no implementation period, that is, no conversion, no extract development, no testing, and no training. There will only be a new contract to sign to continue processing as usual.

This solution is a Graphical User Interface tool that guides the user through potentially fraudulent cases identified by the software. It is a service that we would subscribe to. We would submit monthly data files (claims, encounters, provider, member and reference) which would be deployed on the vendor's system. During deployment the data is analyzed by a proprietary fraud knowledgebase module containing rules and schemes that also factors patterns of behavior and historical data. The product can be used for claims review, and provider and member investigations.

AHCCCS and Med-QUEST OIG, as the principal users of the system, will be given a URL hyperlink to access a login page. On that page the user will enter their username, password, and a security code. Upon login, the user lands on the dashboard which also contains a link to the data analytics product.

The following diagram represents how the solution is currently deployed.

With the recent launch of the proposed vendor's Health Care Portal at AHCCCS, the full re-design of the solution now provides public records data, dashboard information, and trending data including:

- Spike Trending Reports – chart displaying spikes in provider billing volume
- Report Spotlight – highlights the most frequently used Intelligent Investigator Reports
- Rules Spotlight – spotlight on the latest Rules added to Intelligent Investigator
- Trending Chart – chart displaying spikes in provider billing volume

The vendor owns one of the world's largest and fastest growing public records collections, with more than 37 billion records and information on over 274 million

unique consumer identities and 1.4 billion unique business contacts drawn from over 10,000 disparate sources.

The solution uses a unique indexing tool called Composite Lead Indicator (CLI). There are two statistics used when computing CLI: potential savings and probable recovery. As an index, the closer a number is to 100, the higher the probability of recoverable savings. CLI is a product of the potential savings and an index of recoverability. By using CLI to generate qualified leads, users know which providers are most worthwhile to investigate. Searching with qualified leads yields the greatest results, with the least amount of investigative time. Utilizing the system's knowledgebase of rule sets, Intelligent Investigator applies a CLI to all of the transactions in a user's database.

The solution also includes a Provider of Interest (POI) module. This module uses predictive analytics (customer-specific data model attributes built by the vendor) to assign a POI score to each provider. The model attributes are also listed, allowing for drill down analysis.

The system flags providers who have been identified as "needing to be watched" by investigators within the user's organization. Marking them as a "watched provider" enables the SIU team to more efficiently and effectively monitor the provider's activity, based on their history of suspicious claims. Having a provider in the "watched provider" category, allows all the investigators on a team to consistently see how new rule sets applied to these providers identifies new fraud patterns and adds to the knowledgebase.

The system provides comprehensive drill-down capabilities in an easy to navigate manner. No matter where in the system users are, they can simply drill-down without needing to back out and run a new search.

Peer to peer comparisons include the utilization of all providers, not only for procedure codes, but also for modifier, diagnosis, DRG, revenue code, and NDC selection. The system presents these measures visually and provides the user with the ability to easily sort by priority to quickly analyze the system-based evaluation and rankings for further documentation or investigation. Utilization analysis includes the following categories:

- Self Percent – the percentage of this provider's use of this code compared to all procedures for this provider.
- All Percent – the percentage of this provider's use of this code compared to all providers using this code.
- Patient Percent – the percentage of this provider's patients who are billed this code.
- Peer Percent – the percentage of this provider's code use compared to his peers in the same specialty.
- Peer Average – the average percentage of this provider's particular code use compared to his peers in the same specialty.
- Peer Ranking – the comparison of where this provider ranks for utilization of a code compared to his/her peers in the same specialty.

The user can also create their own Peer Utilization analysis by setting minimum percentage thresholds.

Provider detail reports also contain these statistics. High rankings or high concentrations of code usage within any category have proven to identify significant opportunities for recovery. A direct one-to-one comparison exists between the Self Percent and the Peer Average values. An investigator can tell at a glance where a provider strays from peer-group norms, highlighting aberrant use of codes often associated with fraudulent schemes.

Other reports include:
Rule Reports – hundreds of rules are integrated in the system; reports can be created by the user which show claim lines that fired flags by these rules.
Triage Reports – high level and detailed triage reports highlight areas of interest in the data.
Provider Level Reports – in addition to the peer to peer statistics, the user can generate report cards, flagged transactions and claim lines by day for a selected provider.

The system contains hundreds of pre-loaded fraud algorithms which are based on:

- A library of thousands of rules and proven offenses that are updated by the vendor on a quarterly basis.
- Use of industry-proven rules and methodologies such as AMA, CMS, CCI, NHCAA, and other respected sources.
- Full analysis of data (professional, facility, pharmacy, reference files etc.).
- Leveraging all data elements contained in the claim or encounter.
- Cross-Claim analysis.
- Peer-to-Peer comparisons.
- Mathematical relationships.
- Predictive Modeling.
- Clustering analytics.
- Time and geography.

The system is rich in Ad Hoc functionality, providing the user with the ability to generate comprehensive ad hoc queries. Functionality includes support of list, range, and wildcard and plain English usage, allowing the user to thoroughly research the health plan, provider and member activities while enabling the user to validate existing algorithms and to initiate new ones. Advanced Ad Hoc Query allows users to enter two sets of search parameters and filters to perform simultaneous searches against all records in the database. The results show where both criteria scenarios are present in the claims data. The filters are selected by the user and narrow the results to claims that have Any, Same or Different elements (provider, patient, date of service and specialty). The users can also create their own search screens and establish which fields should be searchable.

Link Analysis is supplemented by the vendor's HPCC data base which houses over 16.5 billion consumer records and leverages 37 billion public records from over 10,000 data sources including property, motor vehicles, title records, cell phone numbers, and bankruptcy.

A Help Menu provides online guidance and support on specific system functions and features:
Help Topics window – contains an indexed list of all the functions and features of the system, along with a detailed description.
Code Lookup window – supports searching for codes and code descriptions.
About window – contains product and high-level statistical information.

The proposed vendor has over 25 health plan customers that currently utilize the post-payment FWA solution. At the top of this list is the State of Arizona AHCCCS, as well as University of Arizona Health Plans, Centene, and Amerigroup, all of which do business in Arizona. This list also includes commercial, commercial Medicaid, commercial Medicare and State Medicaid agencies. Well over half of the customers are Medicaid MCOs. They also do business with a large concentration at Commercial Blue Cross Plans, across all of their lines of business.

The proposed vendor fully complies with the MECT Program Integrity checklist. And while the CMS MECT PI Checklist is only required when a State gets a new or replacement MMIS, the proposed vendor fully understands that AHCCCS and Med-QUEST want assurance that the new fraud detection system meets all current CMS PI Checklist standards.

The proposed vendor has evaluated the entire CMS PI checklist and has verified that their product meets all compliance requirements. The Episode of Care Grouper requirement will be met by adding an episode of care grouper product which will make available the data necessary for episode of care analysis. This will then be fed into the solution. This practice is common among all fraud and abuse detection systems on the market.

*C. Quantified Benefits**

- [ ] Service enhancement
- [ ] Increased revenue
- [ ] Cost reduction
- [ ] Problem avoidance
- [x] Risk avoidance

Explain:

The program integrity activities of OIG depend on sophisticated software solutions to effectively identify Medicaid fraud, waste and abuse. AHCCCS and Med-QUEST will maximize their ROI by implementing the appropriate solution. Revenue (recoveries and savings) will be realized after deployment.

The benefits of the proposed vendor's solution are:

1. The vendor offers the best foundational public record data available for Fraud, Waste and Abuse (FWA) detection and prevention.
2. The solution is the most comprehensive.
3. The solution is the most user-friendly.
4. The solution provides 2 methods of detecting and prioritizing FWA (CLI, POI).
5. There are no implementation costs.
6. The solution is the most cost effective.

The reason the recommended vendor was chosen was based on several factors, but primarily – proven success, scope of functionality, ease of use and cost effectiveness. There is no set up required and training of new users is both quick and effective, seldom requiring follow up sessions. Although their ad hoc functionality may not be quite as comprehensive as some alternatives, it is much simpler to operate and far less error prone. Their extensive list of preloaded algorithms and reports is also unmatched by vendors.

The contract serves the best interests of the State and Federal Government by encouraging effective competition or otherwise promoting economies in state procurement. The existing contract expires June 2015 and is not renewable; a new contract is needed to continue such services.

It is in the best interest to allow extension options up to a total of seven (7) years in order to ensure the integrity of data and system performance is continued in an efficient and effective manner to maximize recoveries back to the State and Federal Government. The estimated requirements cover the period of the contract and are reasonable and continuing.

In addition, we expect recoveries directly attributed to this solution to exceed the total product cost within the second year following implementation.

IV. Technology Approach

*A. Proposed Technology Solution**

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B. Technology Environment

The solution is vendor hosted.

C. Selection Process

RFP solicitation and award.

The RFP evaluation was broken into three categories and a maximum point value assigned to each (Requirements 500, Cost 300, Experience 200). Each mandatory requirement was given a weighting of importance (low, medium, high). A corresponding point value was then assigned to each of these to total 500 points. The Cost evaluation was based on a formula (lowest bid/vendor bid * 300).

The proposals were then carefully reviewed by the evaluation team and a total point score determined for each. The results identified three top RFP responses that were worthy of further review. The three vendors were subsequently given one hour to present their solution to the evaluation team under the following guidelines:

- Describe your FWA experience in Medicaid, specifically Medicaid Managed Care in a post payment review
- Demonstrate your solution's drill down and drill across capabilities.
- Present the full range of your pre-loaded algorithms and demonstrate a few examples on how they are initiated and reported.
- Present the scope of user generated advanced ad-hoc features and demonstrate how they complement and enhance your pre-loaded algorithms.
- Describe the types of external data sources currently utilized by your solution and demonstrate how they would enhance AHCCCS' data.
- If included in your solution, demonstrate how geo-spatial, identity resolution, entity relationship analysis and social networking capabilities would enable the AHCCCS user to identify related fraud activities.
- What is your strategy for ensuring your system offers AHCCCS the best FWA solution and what are your plans to evolve your system and add features over the next 5 year period?
- Is there anything else about your system that you want to spotlight that we have not asked about?

After reviewing the presentations, the RFP scoring was updated and the clear winner is the solution being recommended and also the one that is currently in use.

V. Project Approach

*A. Project Schedule**

Project Start Date: 7/1/2015 **Project End Date**: 6/30/2022

B. Project Milestones

Major Milestones	Start Date	Finish Date
Award Contract	-	4/1/2015
Implement Solution	-	6/30/2015
Initial 3-Year Period	7/1/2015	6/30/2018
First Optional 2-Year Extension	7/1/2018	6/30/2020
Second Optional 2-Year Extension	7/1/2020	6/30/2022

VI. Roles and Responsibilities

A. Project Roles and Responsibilities

State Personnel Resources	Description of Responsibilities
Oversight	**Oversee Contract**
Procurement	**Award Contract**

B. Project Manager Certification

	Project Management Professional (PMP) Certified
	State of Arizona Certified
x	Project Management Certification not required

C. Full-Time Employee (FTE) Project Hours

Total Full-Time Employee Hours	
Total Full-Time Employee Cost	

VII. Risk Matrix, Areas of Impact, Itemized List, PIJ Financials

VIII. Project Approvals

A. *Agency CIO Review**

Key Management Information	Yes	No
1. Is this project for a mission-critical application system?	X	
2. Is this project referenced in your agency's Strategic IT Plan?	X	
3. Is this project in compliance with all agency and State standards and policies for network, security, platform, software/application, and/or data/information as defined in http://aset.azdoa.gov/security/policies-standards-and-procedures, and applicable to this project? If **NO**, explain in detail in the "XI. Additional Information" section below.	X	
4. Will this project transmit, store, or process sensitive, confidential or Personally Identifiable Information (PII) data? If **YES,** in the "XI. Additional Information" section below, describe what security controls are being put in place to protect the data.	X	
5. Is this project in compliance with the Arizona Revised Statutes (A.R.S.) and GRRC rules?	X	
6. Is this project in compliance with the statewide policy regarding the accessibility to equipment and information technology for citizens with disabilities?	X	

B. *Project Values**

The following table should be populated with summary information from other sections of the PIJ.

Description	Section	Number or Cost
Assessment Cost (if applicable for Pre-PIJ)	II. PIJ Type - Pre-PIJ Assessment Cost **(staff-only)**	**$0**
Total Development Cost	VII. PIJ Financials tab	**$0**
Total Project Cost (5-year cost)	VII. PIJ Financials tab	**$2,123,123**
FTE Hours	VI. Roles and Responsibilities	**0**

C. *Agency Approvals**

Contact	Printed Name	Signature	Email and Phone
Project Manager:	Geoff Foden		
Agency Information Security Officer:	Jim Wang		
Agency CIO (acting):	Dan Lippert		
Project Sponsor:	Sharon Ormsby		
Agency Director:	Tom Betlach		

IX. Optional Attachments

A. Vendor Quotes

X. Glossary

XI. Additional Information

Once contract is awarded we will describe security controls.

Links:

ADOA-ASET Website

ADOA-ASET Project Investment Justification Information Templates and Contacts

Email Addresses:

Strategic Oversight

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